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WORLD INSURANCE COMPANY'S PROPOSED MEDICARE SUPPLEMENT INSURANCE RATES FOR BANKERS MULTIPLE LINES INSURANCE COMPANY FORMS D-A041, D-A042, D-A044, AND D-A045

FINDINGS, DECISION AND ORDER

I. INTRODUCTION

A. Background and Procedural History

On April 20, 1999, World Insurance Company (World) submitted a request to the Division of Insurance (Division), pursuant to G.L. c. 176K, § 7 and 211 CMR 69.00, *et seq.*, for review and approval of proposed Medicare Supplement Insurance rates for Bankers Multiple Line Insurance Company (BML) policy forms D-A041, D-A042, D-A044, and D-A045. World proposed that the rates be effective for twelve months beginning on October 1, 1999. Pursuant to G.L. c. 176K, the Commissioner of Insurance (Commissioner) must first approve such policy forms and rates. World stated in its filing that these policy forms were originally written by BML, and that they were acquired by World as of April 1, 1996, as part of an agreement to transfer BML's health insurance business to World.

All of the policy forms for which World seeks a rate increase are closed to new enrollment. For forms D-A041 (a guaranteed renewable, attained age rated plan) and D-A044 (a guaranteed renewable, community rated Medicare Supplement Type 1 policy form), World requests that the Commissioner approve rate increases of 74.5 and 78.1 percent, respectively. For forms D-A042 (a guaranteed renewable, attained age rated policy form, with prescription drug coverage) and D-A045 (a guaranteed

renewable, community rated Medicare Supplement Type 2 policy form), World requests increases of 48.1 and 50.4 percent, respectively. Forms D-A041 and D-A042 were sold in 1993 and 1994, and closed to new business in 1994; forms D-A044 and D-A045 were marketed and sold from 1995 to 1997. As of the end of 1998, these forms had the following number of policies in force: D-A041 - 84; D-A042 – 164; D-A044 – 715; and D-A045 – 590.

On April 21, 1999, the Commissioner issued a notice scheduling a public hearing for May 20. The Attorney General (AG), represented by Peter Leight, Esq., and the State Rating Bureau (SRB), represented by Carol Balulescu, Esq., intervened (collectively, the Intervenors). Jason J. Godin, Esq., and Steven L. Goldblatt, Esq., represented World. The Commissioner designated Susan G. Anderson, Esq., and Martha H. Bower, Esq., presiding officers in this matter. The proceeding was conducted pursuant to 211 CMR 121.00, *et seq.*

The public hearing, prehearing and technical conferences took place on May 20. At the public hearing, Mr. Godin, on behalf of World, Mr. Leight, on behalf of the AG, and Ms. Balulescu, on behalf of the SRB, made statements. No other person spoke. At the technical conference, World's witness, John R. Buss, A.S.A., M.A.A.A., responded to questions. In addition, the AG and the SRB requested information in the form of record requests. Cross-examination of Mr. Buss took place on June 15. The AG and the SRB submitted their filings on June 25 and 29, respectively. Stacy D. Book, an actuarial analyst for the AG, and the SRB's witness, Frederick Lonsdale, A.S.A., M.A.A.A., were cross-examined on July 8. World did not submit a rebuttal filing. The parties filed briefs on July 27, and thereafter filed notice that they would not file reply briefs.

B. Standard of Review

The standard of review to be applied to a rate request under Chapter 176K by any carrier, as defined in c. 176K, § 1, is governed by § 7 of that chapter. Subsections 7(d) and 7(g) provide that proposed rates shall not be approved if the benefits provided therein are unreasonable in relation to the rate charged, or if the rates are excessive, inadequate, or unfairly discriminatory or do not otherwise comply with the requirements of Chapter 176K. Subsection (e) of § 7 provides, further, that each Medicare Supplement policy must independently meet specified minimum loss ratio standards.

Subsection 7(g) sets out additional requirements for, *inter alia*, rate filings which request increases which exceed ten percent of the premium previously charged for a product or which relate to new policies issued to comply with Chapter 176K. In addition to being subject to all other provisions of this chapter, such filings require prior approval by the Commissioner before implementation of the requested rate. In granting such approval, the Commissioner must also make a finding, based on information provided by the carrier, that it is employing utilization review programs and other techniques acceptable to the Commissioner which have had, or are expected to have, a demonstrated impact on the prevention of reimbursement by the carrier for services which are not medically necessary.

The standard of review set out in c. 176K, § 7(d) and (g) is identical to that set out in G.L. c. 176A, § 6 and c. 176B, § 4, the statutes which applied to the Commissioner's review of Medicare Supplement rate filings by a hospital and medical service corporation (*i.e.* Blue Cross and Blue Shield of Massachusetts, Inc.) before the enactment of Chapter 176K. Thus, in considering rate filings submitted pursuant to Chapter 176K, the principles enunciated in decisions considering rate review undertaken pursuant to Chapter 176A, § 6 and Chapter 176B, § 4 are pertinent. As under those chapters, the Commissioner, acting under Chapter 176K, does not set rates for the insurance coverage. Rather, the Commissioner's function is to review proposed rates submitted by the carrier to determine whether the rates fall within a range of reasonableness. The burden is on the insurer to produce sufficient evidence in support of its filing, and that evidence must persuade the Commissioner that the proposed rates are reasonable. *Findings, Decision and Order on World Insurance Company's Proposed Medicare Supplement Insurance Rates for Bankers Multiple Line Insurance Company Forms D-A041, D-A042, D-A044, and D-A045* (DOI Docket No. R98-33*) (1998 World Decision*), 5. Proposed rates are entitled to deference if they fall within a range of reasonableness, but the burden is on the carrier to furnish evidence enabling the Commissioner to determine that range. *Blue Cross and Blue Shield of Massachusetts, Inc. v. Commissioner of Insurance,* 420 Mass. 707, 709 (1995); *Massachusetts Association of Older Americans, Inc. v. Commissioner of Insurance*, 393 Mass. 404, 407-408 (1984). The Commissioner is not required to approve elements of the filing which would lead to rates falling within a range of excess or inadequacy, no matter how small. *Blue Cross of Massachusetts, Inc. v. Commissioner of Insurance*, 397 Mass. 117, 119, 124 (1986). A proposal within the range of reasonableness must be approved, even if it is not the one that the Commissioner would choose.

Massachusetts Association of Older Americans, Inc. v. Commissioner of Insurance, 393 Mass. at 407; *Massachusetts Medical Service v. Commissioner of Insurance*, 344 Mass. 335, 339 (1962).

II. RATE DERIVATION

In general, insurance ratemaking involves consideration of three separate components. Benefit costs for the rate year must be projected, an allowance for administrative expenses must be made, and policyholders must receive a credit for investment income earned by the insurer. *Findings, Conclusion and Order Concerning the Filing of Blue Cross and Blue Shield of Massachusetts, Inc. of Proposed Medex Rates and Certificates to be Effective on and after January 1, 1991* (DOI Docket No. G90-34), at 12. Although both Intervenors contend that World's proposed rates must be disapproved, neither Intervenor challenges World's overall ratemaking methodology. The contested aspects of the rates proposed by World are discussed below. On the record of this proceeding, we accept all uncontested elements but make no ruling regarding the reasonableness of the methodologies used to derive them.

A. Claims Costs

World developed its base claims cost for 1994 through 1998 using incurred claims, combining results for policy forms D-A041 and D-A044 (which do not offer drug benefits) and policy forms D-A042 and D-A045 (which do include drug benefits). World assumed that the claims through 1997 were fully developed; for all others, it applied lag factors developed using the claim payment patterns experienced by this block. World then determined the average claims cost for the two sets of policy forms, and, thereafter, calculated the trend from year to year. These year-to-year trends showed considerable variation, from 0.85 (*i.e.*, minus 15 percent) to 1.907 (*i.e.*, 90.7 percent). World stated that in order to produce a smoother annual trend curve, it therefore combined data from all four policy forms. To project claims costs, it used a geometric mean of the combined data for all four policy forms from 1994 to 1998, which produced a unified annual trend of 1.189. Because the midpoint of the base claim period is July 1, 1998, and the midpoint of the proposed rating period is April 1, 2000, it applied 21 months of trend to the base costs to produce its final recommended claims costs.

The AG and the SRB argue that the methodology used by World produces an unreasonable result. Both argue that the claims data should be adjusted to account for a

series of four large claims attributable to a single policyholder. With respect to the trending methodology, both object to World's use of a geometric mean to calculate the trend; the AG objects as well to World's reliance on Massachusetts-only data for trend projection.

First, the SRB and AG point out that the data for policy form D-A044 include several extraordinarily large claims for a single policyholder,[1] incurred in late 1997 and early 1998, and argue that those claims should be eliminated from the data used to calculate claims costs and project the claims trend. World does not dispute that these claims were incurred by a single policyholder, or that they represent a significant percentage of all claims paid on that policy form in 1997 and 1998. However, World argues that it incurred the costs of those claims, and that those costs should therefore be included in the data. The AG and SRB argue that the issue is not whether the claims were incurred, but whether it is reasonable to project 1999-2000 claims costs using these data. They both argue that it is not reasonable to include these claims in the base data, as doing so will distort the claims data and the projected trend, and result in an unreasonable rate. They therefore argue that World's base data should be adjusted to eliminate these claims from the trend calculation.

Next, both the SRB and the AG object to World's use of a geometric mean to calculate the claim cost trends. They argue that because the geometric mean is based on only the first and last data points, and disregards the balance of the claim cost history -- in this case, the data from 1995 through 1997 -- it fails to accurately predict movement from the ending point forward, resulting in an unreasonable trend. The SRB also objects to World's determination of a single trend factor for all policy forms. It argues that the use of a single trend factor produces inaccurate projections, particularly where the data for policies with such different benefits have been combined.

The SRB recommends instead that claim costs be trended separately for the policy forms which do provide prescription drug benefits, and those which do not, and recommends the use of linear regressions to estimate these claim cost trends.

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[1] World notes in its brief that the AG challenged only the three claims which were incurred in 1998; however, as the 1997 claim was irrelevant under the methodology the AG proposed, we will, for convenience, treat the AG's position on the 1997 claim as consistent with the SRB's.

Mr. Lonsdale testified that he first adjusted the data for the non-drug benefit policy forms, D-A041 and D-A044, to remove the effect of the four extraordinarily large claims of policyholder no. 27806. He then performed a linear regression of the adjusted data, producing an annual trend estimate for the non-drug products of 7.76 percent. He also performed a linear regression of the claim cost trend for policy forms D-A042 and D-A045, and produced an annual trend estimate of 12.66 percent. He thereafter developed exponential regressions of these trends, and compared the regression statistics he obtained on both. He testified that he then compared the results of the linear and exponential trends he derived to the data on claims costs. Finally, he compared the trend results to the pure premium trends developed by Massachusetts Blue Cross and Blue Shield for its equivalent products for the period March 1999 through March 2000, which have an experience base of over 100,000 contracts. For its non-drug benefit policy forms, Blue Cross Blue Shield obtained a 4.95 percent annual trend; for the drug-benefit products, a 10.78 percent trend.

Although the AG states that the SRB methodology is preferable to World's because it takes into account the trend over time, he objects to its reliance on data from World's Massachusetts policies. He points to the volatility of the trends experienced on each policy form, pointing out that World acknowledged that the annual trend rates within each group of forms have experienced considerable fluctuation. He also points out testimony from World's actuary, Mr. Buss, that problems with transfer of data from Bankers' Multiple Line may be reflected in the data presented here. The AG argues that because the data themselves are problematic, a trend which is based on national data is likely to be a better predictor of future trends. To project 1999-2000 claims costs, he proposes instead the application to the 1998 claims costs of the ten percent annual claims cost trend approved by the Commissioner in the *1998 World Decision*.

World opposes the SRB's and AG's recommendations to adjust the claims cost data to exclude the claims of a single policyholder, arguing that to do so would result in an inaccurate and understated claims cost. World argues that its 1997 and 1998 claims costs are an accurate representation of claims it has paid, and that a calculation of claims costs that arbitrarily reduces the claims paid produces an understated and erroneous result. It argues that Mr. Lonsdale acknowledged that it would be inappropriate to eliminate the entire amount of these claims.

With respect to the AG's recommendations on trend, World argues that the AG's objection to World's claim trends assumption ignores World's 1999 trend data,

and relies upon data which is not in the record of the current hearing. World argues that because the evidence last year was not made a part of the record this year, it cannot be relied upon here.

World argues that the SRB's proposal is also flawed, because linear regression is biased towards projecting a decreasing trend, and therefore cannot always be relied upon to produce reasonable trend estimates. In addition, it argues, the SRB's own data does not indicate conclusively that linear regression is superior to an exponential analysis. World argues that Mr. Lonsdale failed to consider statistical error in evaluating the difference between linear and exponential regression. World also argues that Mr. Lonsdale's assertion that the data show that trends are decreasing is incorrect, as the record shows that the trends actually either increase or decrease each year.

Analysis

The first issue is whether, in projecting anticipated claims costs, the data for policy form D-A044 should be adjusted for the four extraordinarily large claims for one policyholder. World does not dispute that these claims are unusual; its position is that these claims were paid in the amounts presented, and are therefore properly included in the base data used to calculate the projected costs. However, World's position mistakes the critical question for ratemaking, which is not whether these claims were in fact paid, but whether the costs they represent or claims with similar costs are likely to be incurred during the policy period for which rates are being projected. The record presented here does not provide a basis to conclude that they will.

First, the record supports the conclusion that the four claims identified by the SRB and the AG are clearly extraordinary. For the seventeen-month period beginning August 1997 and ending December 1998, World paid 6,554 claims on policy form D-A044, with an average claim payment of $187.26. Only five claims exceeded $5,000: one of these was for $5704.19, the other four identified claims, totaling $393,217.83, were all attributable to policyholder no. 27806. The first of this series of claims was reported as incurred in November, 1997; for the one-year period beginning that month, all claims paid on policy form D-A044 totaled $1,002,177.67. The four claims for policyholder no. 27806 thus accounted for just under 40 percent of total dollars for all claims submitted during that one-year period, and over 98 percent of total dollars for claims which exceeded $5,000.00.

These four claims are also extraordinary when considered in the context of the claims submitted on the other three policy forms at issue in this proceeding. For all policy forms, including those offering prescription drug benefits, only twelve other claims exceeded $5,000.00, and not only were none as high as any of the four identified D-A044 claims, none was even one tenth as much as the highest claim of the four.

As the AG and the SRB point out, because World has not provided a benefit by benefit breakout of costs, it is impossible to precisely determine the average claim cost by benefit type, and we cannot definitively determine the benefit that gave rise to these extraordinary claims. However, at the technical conference Mr. Buss referred to the first claim as a hospital claim, and given the standard benefits provided by Medicare Supplement I insurance, it is very likely that these claims arose from a lengthy hospital stay. Mr. Lonsdale testified that in instances where companies do provide more detailed information on claim costs by type of benefit, the component for hospital stays is a relatively small portion of the total cost of Medicare Supplement insurance, typically on the order of $6.00 to $7.00 per month. He testified that long hospital stays are quite rare, but that when they occur the claims are quite expensive, as were these claims. Analogizing the ratemaking effect of extraordinary claims for long hospital stays on a Medicare Supplement policy to claims for earthquake damage on a homeowner's policy, he observed that homeowner's premiums do not anticipate annual earthquakes, nor does an earthquake one year justify premiums the next that would cover such extensive claims. He determined that where a claim of this magnitude is rare, it is unreasonable to use it to project the claims cost.

In addition to the distortion that the inclusion of an extraordinarily large claim can introduce into the base data, its position in a series may also distort a projected trend. We note that were these claims at the beginning of the projection period rather than the end, their impact would be to either produce a downward claims cost trend, or exert downward pressure on an increasing trend.

World submitted no evidence that a claim of the magnitude of these would be expected to recur, nor how often it might be expected to recur either within the experience on this policy form or within a larger experience base. Absent such evidence, we cannot find reasonable the inclusion of these claims, in full, in the base

claims data.[2] Rather, the evidence supports the conclusion that these claims are outliers, and that an appropriate adjustment should be made to the data. The SRB and AG argued that the claims should be excluded *in toto*, and World offered no alternative adjustment. We agree that to reflect the anticipated claims level more accurately, the data should be adjusted to account for the extreme size of these four claims. However, we do not find it appropriate to exclude them entirely. We would find reasonable an adjustment to the data which reduced each of the four claim amounts to a level equal to the average of the other claims on this policy form.

The second issue is the projection of claims costs into the rate period. Last year, World proposed the use of a projection methodology which was based on a block of nationwide, prestandardized Medicare Supplement business, which it stated it capped at 14 percent. The Commissioner found the evidence did not support these trends, and ultimately approved a trend of ten percent, based on the same block of nationwide business. World did not use this methodology this year, instead developing a projection based on its Massachusetts policies.

In evaluating the reasonableness of a projection methodology, the principal challenge we confront is that the small number of policies at issue here (fewer than 1,800) constitute a very small set for ratesetting purposes. Further, because this is a closed block of business, this set will shrink, and as it does, the data will become less and less statistically reliable. A comparison of the changes in annual trends for claim costs by paired policy forms to the changes for the four forms in the aggregate shows how volatile a limited set of data can be: the changes by paired form range from minus 15 percent to plus 90.7 percent, while the changes for the four policies in the aggregate fluctuate within a range of only two percent. See, Exhibit 2, p. 10. Further, the aggregation of the four policy forms produced a smoother result, in part, because the up and down changes in the data for the non-drug benefit policies balanced the up and down changes in the data for the policies with drug benefits.

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[2] We note as well that World did not address whether this series of claims was evaluated to ensure that World's cost containment initiatives had worked as well as anticipated, or whether additional programs might have reduced the final costs.

Although World essentially acknowledged the credibility problem presented by such a limited data set when it aggregated the claims data for the four policy forms, its method fails to address the very real differences in claims cost trends for the different policy forms due to the differences in the benefits they provide. Claim costs on those policies which provide prescription drug benefits will be heavily influenced by changes in prescribing patterns and drug costs; the policies which do not provide that benefit will not. Unless one can expect all covered costs to increase or decrease in a unified manner, one cannot expect the claim costs on the different types of policies to change at the same rates. Current Massachusetts and national experience is that these costs do not change in unison, and the trends produced by Mr. Lonsdale's regressions show that World's experience is not the exception. Fairness to consumers who have elected to forego prescription drug coverage requires that they not be charged increased rates based on anticipated increases in the cost of providing that coverage if a more reasonable method is available. For these reasons, we find that a unified trend based on World's Massachusetts-only policies would produce an unreasonable result.

The AG's recommendation, in essence, would adopt a unified trend based on a national data set. This alternative method addresses the problem of a limited data set by utilizing the trend which the Commissioner found reasonable last year, which was based on a national data set. Although this method would produce a trend which is more reliable, and, indeed, more consistent with the trends observed in the recent Massachusetts Blue Cross Blue Shield data, we do not have current national data in the record that would permit a meaningful evaluation of this proposal. Therefore, we do not find reasonable the AG's proposal that the trends be projected based upon the decision last year. We do not, however, reject this proposal on the basis put forward by World, that it relies on evidence outside the record. The Commissioner is always able to consider prior relevant rate decisions in her evaluation of a case. World mistakes the burden it bears in this proceeding to support the reasonableness of its proposal, with that borne by the Intervenors. The Intervenors are not required to present evidence of alternative methodologies.

With respect to World's use of the geometric mean to project claims costs, we agree with the SRB and the AG that it operates to produce a trend based on only the first and last data points in the series, and fails to incorporate in the trend the interim changes in the experience. For estimation of the claim cost trends for the policies at issue in this proceeding, the interim experience is significant. When the experience for

all years is reviewed, it is evident that the methodology proposed by World fails to consider that experience.

The proposal by the SRB, use of a linear trend based on World's data, and compared for reasonableness to a large block of Medicare Supplement business, is a reasonable methodology. World focuses its arguments against the SRB's proposal on Mr. Lonsdale's decision to use a linear, rather than an exponential trend, and the relative similarity of the results of the statistical tests he performed on each of those trend results. These arguments are unpersuasive. First, the data on World's own policies does not show that an exponential trend is appropriate. Although it is correct, as World argues, that the record shows that trends have moved up and down, we conclude that, overall, the trends have exhibited a downward pattern. We point out that a declining trend does not mean that the dollar amount of year to year increases declines, but that as a percentage of the base amount the increase is smaller.

With respect to the statistical tests performed on the results of the projections, we agree that were those test results the only criterion, the choice between the two models would be difficult: although the results of the linear projection are better, the scores for the two methods are quite close. However, as discussed above, this is a very small data set, and its statistical reliability is questionable. The comparison of these results to that produced by a more reliable data set provides a reasonable measure of its reliability. The results of the linear projection compare reasonably to the trends developed by Blue Cross Blue Shield, while the results of the exponential regression do not. Accordingly, we would find reasonable linear projections based on the SRB's methodology.

B. Expenses

Both Intervenors contest World's commission expenses. In addition, the AG argues that both administrative and claims adjustment expenses have been declining as a percentage of premium over the past few years, and may be expected to continue to decline; while he does not recommend a specific adjustment to administrative expenses, he argues that the Commissioner should take account of these decreases in determining future rates.

World included in its filing commission expenses of $14.53 per month for forms D-A041 and D-A044, and $21.66 per month for forms D-A042 and D-A045.[3] The Intervenors oppose the inclusion of any commission expense allowance in the rates.

World derived its commission expense recommendation by dividing the total commissions paid in 1998 by the average inforce policy count, and then dividing the result by 12 to convert to a monthly cost. It then used a reduction factor to adjust the calculation to account for the fact that commissions are only payable for the first six years that a policy is in force, and that some of the policies will enter the seventh year just prior to, or during, the rate projection period. Although commission expenses are typically expressed as a percent of premium, World calculated them as a fixed, per policy cost, because commissions are paid based on the original policy price, not on the later approved premium increase.

In support of its recommendation, World states in its filing that commissions are paid to the writing or servicing agent each month that premium is collected. It states that as of March 31, 1999, it was paying commissions to 102 active agents, each with an average of 12 policies in force. In addition, it states that there are 84 agents who wrote business still in force, but who no longer qualify for commissions because of conditions in their contracts, and that those commissions are paid to an "eligible agent in the hierarchy," up to the general agent. It further asserts that agents are responsible for servicing the business, including answering questions related to the policies and assisting with claim submission if requested.

The SRB and the AG contend that the allowance for agents' commissions is excessive and unreasonable and, citing the *1998 World Decision,* argue that the Commissioner should exclude commission expenses from the rate for the same reasons she articulated last year. Neither disputes that World pays commissions to its agents, nor do they dispute the overall 1998 commission payments presented by World in its filing. Rather, they principally focus their argument on the question of whether consumers receive a benefit from the agents' activities and argue that the policyholders

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[3] The parties agree that this is the same recommendation that World made last year. Actually, last year's recommendations were slightly different: for forms D-A041 and D-A044, it recommended $13.79, and for forms D-A042 and D-A045, it recommended $21.32.

in a closed block of business should not have to pay these commission expenses. In an open block of business, agents' solicitation and sale of new policies benefits policyholders by increasing the pool over which the risk of loss is spread. This, they argue, is the principal benefit insureds receive from agents, and, as the policyholders in a closed block do not receive this benefit, they therefore should not be required to pay commissions. The AG and SRB also dispute the level of direct services to clients provided by agents. They cite the testimony of Mr. Buss, who admitted that he was not aware of the specific functions agents perform.

World argues first that the record contains no evidence of the reasons given by the Commissioner in the *1998 World Decision* for rejecting its proposal last year, how those reasons apply to this rate filing, or how those reasons could consider the new information in World's 1999 filing. It argues that it did provide additional information on commissions and, citing the *1998 World Decision,* that insurance ratemaking includes an allowance for administrative expenses. It states that the AG's recommendation ignores the fact that commissions on these policies were paid to agents in 1998, will be paid in the projected rate period, and are therefore legitimate expenses. Second, World argues that the SRB and AG position relies on the testimony of Mr. Lonsdale, and that his testimony contains errors. World asserts that, contrary to Mr. Lonsdale's testimony that the primary function of agents is to obtain new business, and that none of the agents' efforts benefit the closed block, agents are responsible for providing service to the block of policyholders, including answering questions relating to the policies and assisting with claim submission. It asserts that nothing in the record supports Mr. Lonsdale's testimony that agents are "primarily paid up front or promised continuing commissions for placing business on the books." World argues, third, that disallowance of a commission component in the rate calculation would effectively impose a financial penalty on carriers who close a block of Medicare Supplement business, a result contrary to the intent of Chapter 176K. World also argues that because enrollment of Medicare Supplement policyholders must be done without underwriting, an agent cannot guarantee that new business will be younger or healthier. Finally, citing 211 CMR 71.18, World argues that the Commissioner permits agent compensation arrangements, regardless of whether the block of business is open or closed.

Analysis

Last year, World presented no evidence in its filing to show that commissions were being paid, or in what amounts. Instead, it simply projected the commission amounts based on contracts with BML. Although it provided information, in response to an AG record request, on the number of active and inactive agents, it presented no evidence of actual commissions paid to active agents.

The Commissioner concluded that World had offered no persuasive reason in support of its proposal to require Massachusetts policyholders, in a closed block of business, to pay commissions at the level included in its filing. In reaching this conclusion, she stated:

> The only evidence in support of the amount of commission it seeks to include in the rates is Mr. Buss's testimony regarding the percentages used in BML's original actuarial filing for these policy forms. World did not submit evidence of the nature of the commission agreement with its general agent, or the amount that it agreed to pay as commissions. In addition, it offered no evidence on whether the commissions on these renewal policies will be paid at the same rate as when those policies were first sold. World also did not sufficiently explain to whom the commissions will be paid, and what services, if any, the agents who will receive the commissions will perform for World's policyholders. World's reliance on the sole fact that certain commission levels were originally approved is not a persuasive reason to pass this amount of expense to policyholders.

1998 World Decision at 11.

This year, World asserts that it provided additional evidence. However, it did not, either in its filing or its brief, specifically identify what that additional information was, or how it addressed the concerns raised last year. After carefully reviewing its filing, we have determined that although it has provided additional information, that information is insufficient to allow us to find reasonable the full commission expense allowance World requests.

The evidence offered by World this year addressed the amounts that it paid in commissions in 1998 on these policies, and that it will continue to pay commissions on substantially all active policies during the projected rate period. It calculated its commission request based on commissions paid and adjusted its request to reflect policies on which commissions would no longer be paid. Its filing included testimony

that as of March 31, 1999, it was paying commissions to 102 active agents with an average of 12 policies in force.

Although World disclaims knowledge of the Commissioner's reasons for rejecting the commission expense allowance in its filing last year, it offered evidence that its agents continue to provide services on these policies, including answering questions related to the policies and assisting with claim submission if requested. Furthermore, although Mr. Lonsdale testified that the agent's primary function is to sell new policies, and that agents were "primarily paid up front or promised continuing commissions for placing business on the books," he could not affirmatively state that agents perform no services for current policyholders.

Based on the record this year, World has persuaded us that active agents are available to perform services for policyholders. However, World has failed to provide any information regarding the availability of those agents it characterizes as "eligible agents in the hierarchy" or the general agents to provide service to policyholders. World's filing shows that the 102 active agents with policies in force have assigned to them a total of 1,224 policies. The remaining 543 policyholders, or 30.7 percent, are assigned to an "eligible" or "general" agent. The number of policies which are assigned to these eligible or general agents is significant. On this record we are unable to determine whether policyholders know who the assigned eligible or general agent is, or what services such agent or agents performs for these policyholders. As an important consideration in evaluating the inclusion of a commission expense allowance in the rate is the availability of agents to provide services to policyholders, we cannot find reasonable a commission expense allowance to the extent it incorporates commission payments which are attributable to these "eligible" or "general" agents.

We are also not persuaded that World's calculation of the commission expense allowance for policy forms D-A041 and D-A042 was reasonable. World calculated the commission expense allowance in its rate by combining data from policy forms D-A041 and D-A044, and policy forms D-A042 and D-A045, and determined the average commission payment for each pair of policy forms. It then applied a factor to account for the policies which would enter the seventh duration during the policy year, at which time no further commissions would be payable on the policy form. The filing offered as an example that a policy which was issued in June 1994 would enter its seventh duration in June 2000, and thus, during the policy year for which the rate is projected, would experience only eight months of commissionable exposure. The factors used for

policy forms D-A041 and D-A044 was 0.990, essentially, a one percent reduction, and for policy forms D-A042 and D-A045, 0.926, a 7.4 percent reduction.

The reduction factors World used assume that only a very small percentage of policies will enter the seventh duration during the policy year. However, both policy forms D-A041 and D-A042 were closed to new business in 1994, and thus, during the rate year at issue most, if not all, of those forms will enter the seventh duration. Therefore, on its face, the reduction factor proposed for these policies is unreasonable. World has offered no explanation for pairing for the purposes of this calculation, these policy forms with policy forms D-A044 and D-A045, which were not marketed until 1995. The record does not provide sufficient evidence to allow the calculation of an appropriate reduction factor, and absent such evidence, we find that the request for a commission expense allowance on the D-A041 and D-A042 policy forms is unreasonable.

Accordingly, we would find reasonable in a refiling a proposed commission expense allowance for policy forms D-A044 and D-A045, which applies an additional factor of 0.693 to the commission expense component World requested in its filing, to exclude payments attributable to "eligible" or general agents.

III. ADEQUACY OF COST CONTAINMENT PROGRAMS

Chapter 176K, § 7(g) requires the Commissioner, in reviewing rate requests, to "make a finding on the basis of information submitted by the carrier that the carrier employs a utilization review program and other techniques acceptable to the Commissioner which have had or are expected to have a demonstrated impact on the prevention of reimbursement for expenses that are not medically necessary."

World, in its brief, argues that it has affirmatively demonstrated that it has a broad range of programs to ensure the necessity of medical services to policyholders, implemented a broad range of cost containment programs, continued efforts to evaluate the cost effectiveness of existing programs and demonstrated its intention to add programs and systems which will increase its cost effectiveness. It contends that it has complied with the statutory requirements of c. 176K, § 7(g).

The SRB recommends that the filing be disapproved because World has failed to demonstrate the adequacy of its cost containment programs. The AG recommends no specific rate adjustment based on cost containment and utilization review, but characterizes World's discussion of cost containment as lacking in specificity. He

argues that this makes any rate effect difficult to quantify, and recommends that the Commissioner should consider the existence of such a rate effect in reviewing World's proposed rate.

World's filing includes a summary of 12 cost containment efforts, a copy of an internal memorandum relating to managed care dated December 1998, and a 1998 document entitled "Referral Criteria for Possible Fraudulent Claims." Additional information about its programs was provided in responses to record requests.

World identifies several programs that it has in place or is considering implementing to ensure that it pays claims only for medically necessary procedures and contains costs. First, it automatically refers any skilled nursing claim beyond the 100 days of Medicare coverage to its medical director to determine medical necessity. Second, World has a prescription review program in place, the Diversified AlertCare program, administered by Diversified Pharmaceutical Services (DPS), which helps identify potential problems with insureds' medications and alerts pharmacists when certain drugs are being used either too often or not often enough. Third, all claims originating in a foreign country are adjudicated manually at the home office, must be supported by a typed and itemized bill, and are reviewed for medical necessity. Fourth, World has installed a team to investigate fraudulent claims, and states that detection of fraudulent claims results in demonstrable savings.

Under World's contract with DPS, policyholders are eligible for discounted prices on prescription drugs. Because of the size of the DPS network, it is able to negotiate pricing with more than 50,000 participating pharmacies, leading to cost savings both for World and its policyholders. World has extended its contract with DPS for one year, and anticipates a savings of 3.3 percent of drug claims, or roughly one percent of total D-A045 claims. World further states that it is soliciting contract proposals from several prescription benefit managers to implement a new program which will lead to additional savings in year 2000. World also has a mail order pharmacy service with Advance Paradigm which uses a formulary that typically results in lower net prices.

World asserts that its system of claims processing also leads to cost containment savings. It now pays the majority of its Part B claims through electronic data interchange (EDI) claims submission, which has a system in place to identify potentially duplicate or incorrectly processed bills. World estimates that in the absence of this system, it would require additional claims analysts. World also refers any Part B

claim in excess of $2000 to National Care Network (NCN), an outside vendor, to negotiate repricing. It estimates that it has achieved savings of approximately three to five percent of billed amounts. Moreover, NCN audits and negotiates any Part A bill in excess of $10,000.00 incurred after the 365 days of Medicare hospitalization benefits have been exhausted.

World argues, as well, that it has demonstrated its intent to add programs to increase its cost effectiveness. It states that it is actively developing a new claims adjudication system, currently scheduled for implementation in the third quarter of 1999, that may allow it to track trends which may lead to new cost containment programs, identify and prevent duplicate payments, and expand its use of EDI to process claims. It is also in the process of converting its administrative computer systems from mainframe based software to a LAN based package and anticipates this will lead to increased efficiency, as well as eliminate the need for leasing and maintaining expensive mainframe hardware and software.

World further points to potential savings from the use of a managed care team to investigate and implement existing and new strategies in cost containment. While the team's past efforts have been primarily focused on major medical insurance, World states that it is so encouraged by the savings it has seen in that area that it is currently identifying areas of savings in the Medicare Supplement business.

Finally, World states that it is also evaluating other programs to determine their cost effectiveness. For example, it is negotiating with a third party vendor which specializes in recovery of duplicate payments or overpayments and subrogation of benefits from other parties. It is currently negotiating with PostAcute Care, a vendor that manages terminal illness cases, to determine whether additional savings may be obtained from its services. World is also considering implementing a large case management program, and believes that substantial savings may be obtainable from it, specifically for hospitalization claims that extend beyond Medicare coverage for hospital days. As part of this effort, World entered into a contract with a case management and utilization review company, and is now engaged in a testing phase. In addition, World is reconsidering a code review procedure that is intended to reduce claim costs by ensuring that the company does not pay separately for related procedures. It states that although it terminated a contract with a code review company three years ago because it was not cost-effective, subsequent changes in World's book of business have caused it to reevaluate that decision.

The SRB contends that World has not demonstrated that it has met the criteria of G.L c. 176K, § 7(g) or addressed the specific issues identified in the *1998 World Decision*. It argues that a large portion of the materials presented in World's filing are not relevant to this proceeding, and that any relevant materials failed to provide the projections of savings necessary to meet World's burden and to fulfill the specific instructions issued by the Commissioner last year. Referring to the cost containment efforts identified in World's filing, it argues that World fails to document the projected savings. It cites the specific example of World's inability during the technical conference to respond to questions concerning the projected rate impact for either the updated administration system or the updated claims adjudication system, and it points out that World was unable to demonstrate projected rate impacts on most of the other cost containment measures. Further, it argues that the memorandum on managed care is largely irrelevant to cost containment efforts in this proceeding, because World's Medicare Supplement policies are indemnity policies, not managed care contracts. In addition, it argues that World's presentation on fraud control does not demonstrate savings, as the fraud team is not charged with quantifying savings.

The SRB further asserts that World's explanation of its pharmacy benefit is muddled, that some features do not apply to Medicare Supplement policies, and that some features are available even to policyholders who do not have a prescription drug benefit. Moreover, it argues, some of the savings result from discounts, and a mere showing of the existence of discounts does not demonstrate prevention of reimbursement for purchases that are not medically necessary. In conclusion, the SRB argues that World has failed to provide the Commissioner with sufficient information upon which to find a demonstrated impact on the prevention of reimbursement for services that are not medically necessary, and contends that World has not demonstrated that it has made progress in these areas since its last filing. Thus, the SRB recommends that the Commissioner disapprove the rate filing.

In the alternative, the SRB recommends that if the Commissioner does not disapprove the filing for failure to document the cost containment required under the statute, such failure should nevertheless be considered in any overall rate increase she might grant. This is so, it argues, because it is inappropriate for policyholders to pay for World's failure to implement cost containment measures that could have lowered claim costs and reduced the size of any increase.

In the *1998 World Decision*, the Commissioner declined to disapprove World's filing for failure to satisfy the statutory standard. She found that World had a number of programs in place to meet the statutory goal, and found no basis in the record to question the credibility of World's general statements regarding its efforts at utilization review, although she noted that it had not provided data in support of past or projected savings. She further found that World had demonstrated that it had programs in place to address other aspects of cost containment; she cited negotiating discounts and increased efficiency as important cost containment efforts. *1998 World Decision* at 22-23. However, the Commissioner cautioned World that in the future it would be expected to provide more specific data on anticipated savings resulting from its cost containment and utilization review programs. She concluded:

> Although World apparently has limited access to long term expense and claims data on these policy forms, it should have more complete data in the future. I note, in particular, that World anticipates having a new claims administration system in place by the end of this calendar year. Therefore, for any filing for a future rate year, World should include a review [of] its cost containment and utilization review efforts, and should affirmatively demonstrate the impact of its measures. In addition, it should demonstrate adequate progress in the development of these efforts.

Id. At 23.

A comparison of the programs described in last year's decision with those World offers this year as evidence of its cost containment efforts shows the following. Last year World anticipated that a new claims administration system, that would enable it to track claims by benefit and identify areas in which to implement additional efforts to reduce fraudulent, unnecessary and duplicate claims, would be in place by the fourth quarter of 1998. World did not meet that target; the system is now scheduled for implementation in the third quarter of 1999. World did not explain the delay in implementation, nor did it offer a projected rate impact. Notwithstanding this delay, in this filing World offered some evidence on savings anticipated through some of its measures, although the impact of most of its efforts is still unquantified.

Specifically, on three programs that were in place last year, World has quantified savings: its extended contract with DPS; its claims processing system for Part B claims; and its referral of claims in excess of $2000 to NCN to renegotiate pricing.

For other programs, World has not yet quantified the savings impact. For example, World has not projected a rate effect from the conversion of its administrative computer systems. In a number of other areas, World reiterates the existence of programs that it described in last year's proceeding, but fails to demonstrate progress in documenting savings. As an example, World again mentions its procedure for handling foreign claims, but does not identify any quantifiable costs savings identified with that program. Similarly, the DPS AlertCare Program was in place last year, and World has not shown this year that it is associated with any documented savings. Last year World referred to savings from its use of a mail order prescription program; it mentions this program again this year, but does not demonstrate what the savings impact has been.

The *1998 World Decision* notes that as part of its cost containment efforts, World referred to its review of claims over $500 for possible subrogation. This year, it states that it is negotiating with a third party vendor that specializes in recovery of duplicate payments or overpayments and subrogation to address savings through third party recoveries. World does not explain any differences between the program in place last year and this year, the reasons for engaging an outside vendor to perform this function, or its expectations for future improved results or cost savings.

World identifies three new programs in it filing. One, provided through PostAcute Care, is expected to contain costs through management of terminal illnesses. However, World does not attempt to quantify any savings it will achieve. World also identifies two other new programs, a fraud control initiative and use of a managed care team to investigate and implement existing and new strategies developed in World's core business, Major Medical Insurance. It quantifies no savings from the former, stating only that "anecdotal" evidence from team members indicates that there is sufficient fraudulent activity to justify the team as a cost saving measure, and as a deterrent device. Although World states that managed care resulted in a 17.7 percent reduction in billed charges in 1998 for the major medical program, it also states that it has not yet put Medicare Supplement into this type of managed care, and projects no rate effect.

We are not persuaded on this record that either the fraud control or managed care initiatives are relevant to our evaluation of World's cost containment efforts: World has made no attempt to link any aspect of the fraud program to its Medicare Supplement business. As the SRB points out, World's Medicare Supplement is an indemnity plan, and managed care concepts and strategies are therefore not directly

relevant to it. In the future, World is advised to distinguish cost control efforts that do not relate to this line of business, and to analyze more carefully how cost containment efforts of general applicability affect Medicare Supplement claims.

Based on this record, we find that World has made some progress in its efforts to demonstrate that its utilization review program and cost containment programs have had or are expected to have an impact on the prevention of reimbursement by the carrier for services that are not medically necessary. However, progress has been slow, and we again caution World that it must continue to evaluate its programs. In the *1998 World Decision*, the Commissioner specifically advised World, in the future, to include a review of its cost containment and utilization review efforts, affirmatively demonstrate the impact of its measures, and show adequate progress in the development of these efforts. For unexplained reasons, the system that, according to World, would assist it in satisfying these requirements is not yet in place, although it is expected to be implemented shortly. We reiterate that, in any future rate filing, World will be expected to comply with the Commissioner's directives articulated in the *1998 World Decision.* Nevertheless, we conclude that it has taken some steps toward satisfying the statutory standard, and decline to reject the filing for failure to do so.

IV. CONCLUSION

Based on the foregoing findings and conclusions, it is ordered that the filing of World Insurance Company for review and approval of proposed Medicare Supplement Insurance rates for Bankers Multiple Line Insurance Company policy forms D-A041, D-A042, D-A044, and D-A045 to be effective on and after October 1, 1999 is hereby disapproved to the following extent:

The proposed rates for the four plans are hereby disapproved. In particular World's proposed claims costs and commission expense allowance are found to be unreasonable. We would accept as reasonable proposed rates that incorporate the claim cost projection and commission expense allowance that this decision states would be considered reasonable.

Pursuant to 211 CMR 121.25, World may submit revised rate filings for the above products. Such filings shall contain the rates which would be found reasonable in accordance with this decision, with appropriate supporting calculations and data. Such filings shall incorporate all appropriate adjustments to rate calculations affected by the determinations made in this decision. Such filings may incorporate by reference

those portions of the pending rate filing supporting components of the rates found to be within the range of reasonableness.

World shall mail notice of the rates, if approved, to all policyholders no later than 25 days before such rates take effect. Accordingly, such filing shall also include a form of notice to all policyholders of the approved rates. The notice shall include the rate effective date applicable to different classes of policyholders, based on billing cycles.

If such a Revised Rate Filing is submitted by 4:00 p.m. on August 25, 1999, a hearing will be held at 10:00 a.m. on August 30, 1999, to consider whether further proceedings are necessary to review the rate requested in the Revised Rate Filing.

So Ordered.

August 19, 1999

Martha H. Bower, Esq.
Presiding Officer

Susan G. Anderson, Esq.
Chief Hearing Officer
Presiding Officer

AFFIRMED:

August 19, 1999

Linda Ruthardt
Commissioner of Insurance

This decision may be appealed in accordance with the provisions of G.L. c. 176K.